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Enclosure (6)

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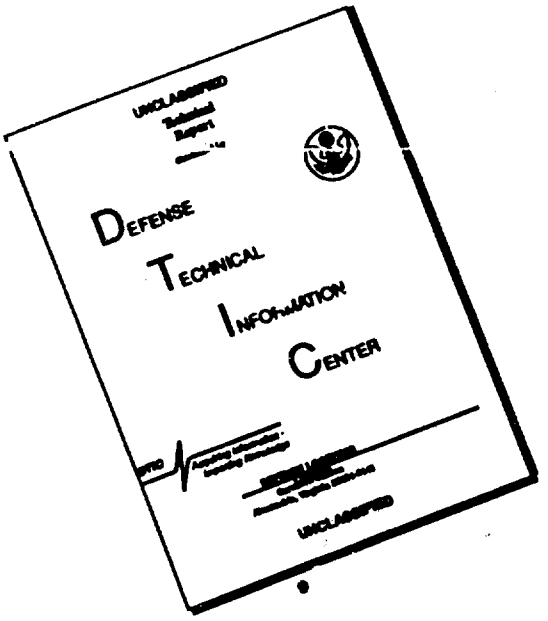


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# Home From the War: A Study of Psychiatric Problems in Viet Nam Returnees

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*Fifty patients who developed psychiatric problems after return from tours of Viet Nam combat duty were compared with a group of patients who had not had such duty. The Viet Nam returnees reported more conflicts in intimate relationships and had a higher incidence of depression and somatization than did the noncombat group. Although the returnees manifested more aggressive and suicidal threats, they did not evidence more direct aggressive or suicidal behavior. The authors suggest that although Viet Nam returnees face significant readjustment stress, their reactions are generally internalized and their potential for violent aggression is no greater than in those without Viet Nam experience.*

IN PREVIOUS WARS and in Viet Nam, psychiatric problems in combat have been much studied. There is also, however, great potential value in studying the longer-range psychological effects of combat and particularly the problems of servicemen's readjustment to a noncombat environment. These subjects were discussed during and following past wars, particularly World War II(1, 2), but there has been little significant study of such problems in the present Viet Nam conflict. One professional publication (3) has dealt with psychiatric problems among Viet Nam returnees; this was a general discussion of ten patients, six of whom had completed full tours in the combat zone.

In contrast to this relative paucity of published clinical data there has been considerable comment in the press about readjustment problems in Viet Nam returnees, indicating the understandable concern of the civilian population about the social as-

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Opinions expressed herein are those of the authors and do not necessarily reflect the views of the Department of the Navy.

TABLE 1
Percent of Patients with each Diagnosis in the Three Groups Studied

| DISCHARGE DIAGNOSES | OVERALL PSYCHIATRIC ADMISSIONS | VIET NAM RETURNEES (POSTCOMBAT) | NON-VIET NAM RETURNEES (NONCOMBAT) |
|---|---|---|---|
| Psychosis | 23 | 28 | 16 |
| Neurosis | 20 | 22 | 14 |
| Personality disorder (including situational reaction) | 54 | 50 | 66 |
| No disease | 4 | 0 | 4 |

pects of such problems. This paper presents the findings of an initial screening survey of psychiatric problems in Viet Nam returnees at the Philadelphia Naval Hospital. It is hoped that these data can identify some significant aspects of postcombat adjustment and encourage scientific study and discussion rather than subjective speculation about the topic.

## Method

A series of 50 Marine and Navy subjects was compiled from inpatients admitted to the neuropsychiatric treatment center, Philadelphia Naval Hospital, between November 1967 and December 1968, utilizing the following criteria: 1) completion of assigned tour of duty in the Viet Nam combat zone, and 2) onset of or hospitalization for psychiatric problems within one year after return from Viet Nam. Patients medically evacuated from Viet Nam were excluded from this series, as were all other patients who had not completed their assigned combat tours for a variety of reasons. The series included only those who had served their time in the combat area and who had emotional difficulties requiring hospitalization following their return to the continental United States. These cases were located and compiled from a review of patient records and from cases reported by the attending psychiatrists. These 50 cases were found to consist of 42 Marine and eight Navy patients, with a mean age of 22.5 years and a mean length of service of 47.6 months.

For comparison, a second group was compiled of patients who had not had Viet Nam service. An attempt was made to select those of roughly equivalent age, service branch, and length of service, otherwise utilizing random choice. When completed, this group without war zone experience also had 42 Marine and eight Navy patients, with a mean age of 21.5 years and a mean length of service of 36.1 months. Hospitalization records of the two groups were reviewed. Pertinent clinical and historical data were extracted and compared in an effort to determine patterns of difference and/or similarity between the groups. The results follow.

## Results

### *Diagnostic and Dispositional Patterns*

Table 1 presents diagnostic data for the two groups and compares them with total psychiatric inpatient diagnostic data for the same period (November 1967-December 1968). It must be noted that the psychiatric treatment center at Philadelphia Naval Hospital is a final echelon evacuation hospital, so the admissions include a greater percentage of severe and clinically or administratively complicated psychiatric problems than would be found in other naval facilities. Thus, the caseload statistics do not reflect the overall incidence of emotional illness or dispositional trends of the general Navy/Marine population.

It is apparent that the incidence of psychosis was higher in the postcombat group than in the noncombat group but similar to that of the general psychiatric caseload. Psychoneurosis was also higher in the postcombat group than in the noncombat series and again roughly equivalent to that of the overall admissions. Personality disorder was diagnosed much less often in the postcombat group than in the noncombat group but approximately the same as in the general caseload.

The disposition statistics (table 2) basically reflect the diagnostic patterns, with fewer postcombat men returning to duty or being administratively separated; more were referred to the Physical Evaluation Board for consideration of a potentially service-incurred or service-aggravated disability. To

TABLE 2

Percent of Patients with Various Dispositions in the Three Groups Studied

| DISPOSITION | OVERALL PSYCHIATRIC ADMISSIONS | VIET NAM RETURNEES (POSTCOMBAT) | NON-VIET NAM RETURNEES (NONCOMBAT) |
|---|---|---|---|
| Duty | 33 | 28 | 30 |
| Administrative separation (narrative summary and Medical Board) | 33 | 32 | 46 |
| Physical Evaluation Board | 25 | 36 | 16 |
| Discharge, physical disability | 6 | 4 | 8 |
| Miscellaneous | 3 | | |

summarize, the distribution of diagnostic categories was similar in the postcombat group and the general psychiatric population but differed from the noncombat group, in which there were fewer psychoses and considerably more personality disorders. This may well result from selection factors inherent in the difficult task of finding Marines with two or three years of service but without combat experience for inclusion in the second group.

*Clinical Factors*

Table 3 compares clinical factors in the combat and noncombat groups. The Viet Nam returnees had less history of antisocial behavior (legal difficulties) prior to their current illnesses than did the noncombat patients. They also had a lower incidence of psychiatric contacts prior to current illnesses than did the second group. These findings are consistent with the greater number of personality disorders in the latter group. The Viet Nam returnees, however, had a higher percentage of legal difficulties temporally related to their current hospitalization than did the other group as well as a higher number of problems related to alcohol and more conflict in intimate relationships.

Particularly interesting are the comparative patterns of internally and externally directed aggression. Suicidal attempts or gestures related to current hospitalization occurred with similar frequency in both the postcombat and noncombat groups. Suicidal threats or preoccupations, however, were much more frequent in the postcombat patients. Related to this and of special interest are the findings concerning externally directed aggression. Overt aggressive behavior occurred with equivalent frequency in the

TABLE 3

Clinical Factors Identified in Viet Nam Returnees and Non-Viet Nam Returnees

| FACTORS | VIET NAM RETURNEES NUMBER | VIET NAM RETURNEES PERCENT | NON-VIET NAM RETURNEES NUMBER | NON-VIET NAM RETURNEES PERCENT |
|---|---|---|---|---|
| Prior to present illness | | | | |
| Antisocial behavior | 22 | 44 | 29 | 58 |
| Prior psychiatric contact | 11 | 22 | 16 | 32 |
| Associated with present illness | | | | |
| Antisocial behavior | 22 | 44 | 16 | 32 |
| Alcohol misuse | 17 | 34 | 10 | 20 |
| Conflict in intimate relationships | 28 | 56 | 20 | 40 |
| Suicidal attempts or gestures | 8 | 16 | 6 | 12 |
| Suicidal threats or preoccupations | 13 | 26 | 6 | 12 |
| Aggressive behavior | 12 | 24 | 13 | 26 |
| Aggressive preoccupations | 9 | 18 | 8 | 16 |
| Aggressive threats | 10 | 20 | 4 | 8 |
| No aggressive problems | 30 | 60 | 26 | 52 |
| Anxiety with somatization | 16 | 32 | 11 | 22 |
| Anxiety without somatization | 5 | 10 | 13 | 26 |
| Anxiety (total) | 21 | 42 | 24 | 48 |
| Depression with somatization | 17 | 34 | 7 | 14 |
| Depression without somatization | 14 | 28 | 15 | 30 |
| Depression (total) | 31 | 62 | 22 | 44 |

two groups, as did aggressive preoccupations. However, aggressive threats were significantly more frequent in the postcombat group. It is also noteworthy that in 60 percent of the Viet Nam returnees there were no aggressive problems either in overt behavior, threats, or preoccupations, as compared to 52 percent of the noncombat patients. This suggests that aggressive problems may not be more common following exposure to combat experience. More specifically, direct behavioral expression of aggressive conflicts did not appear to be increased among postcombat patients, although threats and preoccupations with such conflicts seemed more likely to occur.

Subjective manifestations of emotional disorder were tabulated (table 3), specifically affective and somatic symptoms including anxiety and depression with or without somatization. Generalized anxiety symptoms occurred with only minor differences in incidence. There was a greater difference in somatic manifestations of anxiety, however, with more Viet Nam returnees having such documented physical symptoms than the noncombat group. Of interest is the finding that depressive syndromes occurred in a significantly greater number of the Viet Nam returnees, again with much more somatization. The increased amount of somatization suggests more internalization and more significant neurotic psychopathology in the postcombat group, and the frequency of depression hints at some of the psychodynamics of these returnees.

## Discussion

It is important to emphasize that this screening study involves such a small series that any generalizations are speculative, based upon statistical hints. Yet interesting ideas are suggested by the findings.

It would appear that the Viet Nam returnees who develop psychiatric problems have a somewhat greater incidence of disciplinary and alcohol difficulties than do their peers who have not served in the combat zone. Certainly this is consistent with what many military psychiatrists believe they have observed and may be part of a common readjustment syndrome. Many returnees complain bitterly of the more rigid military structure of stateside duty, with its more "spit-and-polish" environment and inflexible authority relationships compared to the combat zone milieu. Displacement of hostility onto authority figures and the military service in general frequently results in impulsive infractions of regulations and defensive use of alcohol. Even so, such behavior occurs in less than half of the postcombat group.

The frequency of conflicts in intimate relationships (with families and girl friends) and the high incidence of depression in the Viet Nam returnees are both consistent with the findings of Goldsmith and Cretekos(3) and tend to validate the speculations of those authors as well as the formulations of Grinker(4) in World War II concerning the importance of dependency problems in the psychiatric disorders of combat veterans. It is theorized that while participating in combat the individual's dependency needs are gratified by the strong group identification of the combat unit, supplemented by an active fantasy life consisting of rosy daydreams about how wonderful life at home will be upon return. The reality of coming home rarely matches this fantasy and, in fact, may involve actual rejection as well as the usual requirements for adult, independent, responsible behavior such as that of a husband and father. In the face of these frustrations of dependency needs, depressive syndromes are predictable. Whether residual factors of guilt, mourning, or problems of self-esteem stemming from combat experience are generally significant in these postcombat depressions is debatable.

Our experience with combat psychiatric casualties in Viet Nam indicated a high incidence (54 percent) of depression there(5), suggesting that problems with guilt and responsibility are as important and frequent in acute combat-precipitated disorders as the stress of situational fear and resultant anxiety syndromes. This present study clearly suggests that among returnees from Viet Nam, anxiety syndromes may also be no more common than among noncombat patients. Among those returnees with both depressive and anxiety symdromes, however, there is a greater tendency to manifest conflicts somatically. As the noncombat group had such a high percentage of personality disorders, one may speculate that their reporting of affective states without definite

physical manifestations of these states indicates more superficial disorder. The postcombat group, however, demonstrated the somatic as well as the psychological aspects of their depression and anxiety.

There has always been much interest and anxiety about combat veterans' aggressive potential. This is a valid social concern, kept active by occasional well-publicized incidents of violence involving servicemen and ex-servicemen. The data in this study suggest that Viet Nam veterans are no more likely than non-Viet Nam veterans to be preoccupied with aggressive conflicts or to act out such conflicts, although they may be more likely to make aggressive threats. Consistent with this, the Viet Nam veterans seem to be no more likely to act out self-destructive impulses than other servicemen without combat experience but more likely to threaten such self-destructive behavior.

It would appear that combat zone experience does not eradicate controls of either internally or externally directed overt aggressive behavior, although such controls may be temporarily overcome by group sanction, survival needs, and other factors in combat. Experience in the combat zone verifies the fact that the control of verbal and other indirect expression of aggression is also decreased in the combat environment. It is quite socially approved to talk about aggressive feelings and even to threaten; this decrease in the taboo against aggressive talk and threats apparently is more likely to continue after leaving combat than is the decrease in actual control of direct aggressive expression. It is noteworthy that aggressive problems of all types were slightly less frequent in the Viet Nam returnees than in the noncombat group. It is our speculation that the aggressive potential of Viet Nam returnees is much overrated. Our figures indicate that the combat veteran may be more likely to talk about violence but no more likely to behave violently.

This is not a new finding but reflects the experience of past wars. In 1945 Grinker(4) noted that returnees from combat showed more aggressiveness and hostility in their verbalizations and behavior. Concerning direct acting-out of aggression, however, Grinker wrote:

> Have we not heard that war creates a new type of superego that permits and condones release of aggression and facilitates abandonment of old repression? Was not one of the major sociological problems after the war supposedly to be concerned with the animal-like warriors whose unleashed hostilities, no longer directed against the enemy, would be directed against society? It has become quite obvious that for the majority of men, removal of external prohibitions against killing and even encouragement of human destruction do not develop a killer. Neither the soldiers of the First World War nor those of the British, Canadian or French armies of this war reacted in this way. Normal men nurtured by American civilization do not care to kill, even though external prohibition embodied in law, regulation, and police are removed.

Our present data concerning returnees from Viet Nam indicate that these statements are as valid today as they were in 1945. It is important that this be recognized in view of the sometimes emotional reaction to violent incidents involving service personnel and veterans when they do occur.

## REFERENCES


1. Braceland FJ: Psychiatry and the returning veteran. Ment Hyg 30:33-46, 1946
2. Grinker RR: Psychiatric disorders in combat crews overseas and in returnees. Med Clin N Amer 29:729-739, 1945
3. Goldsmith W, Cretekos C: Unhappy odysseys: psychiatric hospitalizations among Vietnam returnees. Arch Gen Psychiat 20:78-83, 1969
4. Grinker RF, Spiegel JP: Men Under Stress. Philadelphia, Blakiston, McGraw-Hill Book Co. 1945, p 308
5. Strange RE, Arthur RJ: Hospital ship psychiatry in a war zone. Amer J Psychiat 124:281-286, 1967